

		FOR OFF USE					

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**2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0037853</u>  <b>Facility Name:</b> <u>HERITAGE MANOR-DWIGHT</u>  <b>Address:</b> <u>300 MAZON STREET</u> <u>DWIGHT</u> <u>61701</u> <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Number</span> <span>City</span> <span>Zip Code</span> </div> <b>County:</b> <u>LIVINGSTON</u>  <b>Telephone Number:</b> <u>( 815 ) 584-1240</u> <b>Fax #</b> <u>( )</u>  <b>IDPA ID Number:</b> <u>370909086015</u>  <b>Date of Initial License for Current Owners:</b> <u>03/06/92</u>  <b>Type of Ownership:</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> <u>          </u> </div> <div> <input checked="" type="checkbox"/> <b>PROPRIETARY</b>  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other <u>                                </u> </div> <div> <input type="checkbox"/> <b>GOVERNMENTAL</b>  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other <u>          </u> </div> </div>	
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**In the event there are further questions about this report, please contact:**  
**Name** CRAIG L. ATER **Telephone Number:** ( 309 ) 823-7135

DPA 3745 (N-4-99)

IL478-2471

**Print Preview**



Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853 Report Period Beginning: 01/01/01 Ending: 12/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	17,728	5,256	3,215	26,199	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	17,728	5,256	3,215	26,199	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4 78.02%)D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
none

F. Does the facility maintain a daily midnight census? \_\_\_\_\_

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started 1989J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 1989 NO ☐K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided 3,215Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☐ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_  
\* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	5256	5256	0
IPA	17732	17732	0
medicare	3215	3215	0
	26203	26203	
IPA BEDHOLDS	4		
PP BEDHOLDS	0		
PP CONVERS	0		

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning: 01/01/01

Ending: 12/31/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	155,365	8,134	0	163,499		163,499	2,844	166,343		1
2	Food Purchase		101,800		101,800		101,800	(526)	101,274		2
3	Housekeeping	70,714	12,993		83,707		83,707	0	83,707		3
4	Laundry	38,853	11,422		50,275		50,275	0	50,275		4
5	Heat and Other Utilities			99,702	99,702		99,702	1,158	100,860		5
6	Maintenance	39,345	40,567	22,998	102,910		102,910	9,122	112,032		6
7	Other (specify):*							0			7
8	<b>TOTAL General Services</b>	304,277	174,916	122,700	601,893		601,893	12,598	614,491		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600	0	9,600		9
10	Nursing and Medical Records	850,598	62,169	95,718	1,008,485		1,008,485	0	1,008,485		10
10a	Therapy		198,204	127,253	325,457	(304,749)	20,708	89,169	109,877		10a
11	Activities	33,247	2,868	0	36,115		36,115	0	36,115		11
12	Social Services	35,191	0	2,400	37,591		37,591	0	37,591		12
13	Nurse Aide Training	0	50		50		50	1,700	1,750		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16		919,036	263,291	234,971	1,417,298	(304,749)	1,112,549	90,869	1,203,418		16
	<b>C. General Administration</b>										
17	Administrative	59,542			59,542		59,542	25,207	84,749		17
18	Directors Fees							3,947	3,947		18
19	Professional Services			193,882	193,882		193,882	(179,125)	14,757		19
20	Dues, Fees, Subscriptions & Promotions			80,187	80,187	(50,370)	29,817	(13,882)	15,935		20
21	Clerical & General Office Expense	82,245	7,114	13,103	102,462		102,462	136,870	239,332		21
22	Employee Benefits & Payroll Taxes			187,730	187,730		187,730	19,428	207,158		22
23	Inservice Training & Education			541	541		541	746	1,287		23
24	Travel and Seminar			8,279	8,279		8,279	(6,280)	1,999		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			21,065	21,065		21,065	1,398	22,463		26
27	Other (specify):*			33,123	33,123		33,123	(32,341)	782		27
28	<b>TOTAL General Administration</b>	141,787	7,114	537,910	686,811	(50,370)	636,441	(44,032)	592,409		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,365,100	445,321	895,581	2,706,002	(355,119)	2,350,883	59,435	2,410,318		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number **HERITAGE MANOR-DWIGHT**# **0037853**Report Period Beginning: **01/01/01** Ending: **12/31/01****V. COST CENTER EXPENSES (continued)**

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			113,719	113,719		113,719	6,131	119,850		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			28,058	28,058		28,058	(176)	27,882		32
33	Real Estate Taxes			37,149	37,149		37,149	0	37,149		33
34	Rent-Facility & Grounds			131,876	131,876		131,876	6,535	138,411		34
35	Rent-Equipment & Vehicles			5,295	5,295		5,295	10,413	15,708		35
36	Other (specify):*							0			36
37	<b>TOTAL Ownership</b>			316,097	316,097		316,097	22,903	339,000		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers					304,749	304,749	0	304,749		39
40	Barber and Beauty Shops	0	0	8,130	8,130		8,130	0	8,130		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee					50,370	50,370	0	50,370		42
43	Other (specify):*							0			43
44	<b>TOTAL Special Cost Centers</b>			8,130	8,130	355,119	363,249		363,249		44
45	<b>GRAND TOTAL COST</b>										
	<b>(sum of lines 29, 37 &amp; 44)</b>	1,365,100	445,321	1,219,808	3,030,229	0	3,030,229	82,338	3,112,567		45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **HERITAGE MANOR-DWIGHT**

# **0037853**

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	<b>NON-ALLOWABLE EXPENSES</b>				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,235)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(97)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(526)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(837)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,579)	24		19
20	Contributions	0	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(595)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,341)	27		24
25	Fund Raising, Advertising and Promotional	(16,766)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (65,976)		\$	30

**OHF USE ONLY**

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	148,314		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 148,314		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 82,338		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Print Preview







**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.**

**IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb HERITAGE MANOR-DWIGHT

# 0037853 Report Period Beginning:

01/01/01

Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary  
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>A. General Services</b>														
1	Dietary	0	0	2,844	0	0	0	0	0	0	0	0	2,844	1
2	Food Purchase	(526)	0	0	0	0	0	0	0	0	0	0	(526)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,158	0	0	0	0	0	0	0	0	1,158	5
6	Maintenance	0	0	9,122	0	0	0	0	0	0	0	0	9,122	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	(526)	0	13,124	0	0	0	0	0	0	0	0	12,598	8
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(12,791)	0	0	101,960	0	0	0	0	0	0	89,169	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,700	0	0	0	0	0	0	0	0	1,700	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Program</b>	0	(12,791)	1,700	0	101,960	0	0	0	0	0	0	90,869	16
<b>C. General Administration</b>														
17	Administrative	0	0	25,207	0	0	0	0	0	0	0	0	25,207	17
18	Directors Fees	0	0	3,947	0	0	0	0	0	0	0	0	3,947	18
19	Professional Services	(595)	0	9,679	0	(188,209)	0	0	0	0	0	0	(179,125)	19
20	Fees, Subscriptions & Promotions	(17,603)	0	3,721	0	0	0	0	0	0	0	0	(13,882)	20
21	Clerical & General Office Expenses	0	0	136,870	0	0	0	0	0	0	0	0	136,870	21
22	Employee Benefits & Payroll Taxes	0	0	19,428	0	0	0	0	0	0	0	0	19,428	22
23	Inservice Training & Education	0	0	746	0	0	0	0	0	0	0	0	746	23
24	Travel and Seminar	(11,579)	0	5,299	0	0	0	0	0	0	0	0	(6,280)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,398	0	0	0	0	0	0	0	0	1,398	26
27	Other (specify):*	(32,341)	0	0	0	0	0	0	0	0	0	0	(32,341)	27
28	<b>TOTAL General Administration</b>	(62,118)	0	206,295	0	(188,209)	0	0	0	0	0	0	(44,032)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(62,644)	(12,791)	221,119	0	(86,249)	0	0	0	0	0	0	59,435	29

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary  
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	6,131	0	0	0	0	0	0	0	6,131	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(97)	0	0	(79)	0	0	0	0	0	0	0	(176)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,535	0	0	0	0	0	0	0	6,535	34
35	Rent-Equipment & Vehicles	(3,235)	0	0	13,648	0	0	0	0	0	0	0	10,413	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,332)</b>	<b>0</b>	<b>0</b>	<b>26,235</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>22,903</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(65,976)</b>	<b>(12,791)</b>	<b>221,119</b>	<b>26,235</b>	<b>(86,249)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>82,338</b>	<b>45</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number: HERITAGE MANOR (00000001)

STATE OF ILLINOIS

Report Period Beginning: 01/01/01

Ending: 12/31/01

Page: 6

Show Pgs 6A thru 6

Show Pgs 6B thru 6

Show Pgs 6A thru 6B

VI. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	City

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  
☐ Yes ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Schedule V Line	1	2	3	4	5	6	7	8
	Cost to Related Organization	Portion of Related Organization	Operating Costs of Related Organization	Adjustments to Related Organization Costs (Section 6)				
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
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41								
42								
43								
Total								

Total must agree with the amount recorded on line 36 of Schedule V.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.

2. For pages 6 thru 6B, the information you enter does not need to be sorted by line reference.

3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.

4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.

5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Preview

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-12791

Line 1 2 3 4 5 6 7 9 10 10a 11 12 13 14 15 17 18 19 20 21 22 23 24 25 26 27 30 31 32 33 34 35 36 38 39 40 41 42 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-DWIGHT STATE OF ILLINOIS # 0037853 Report Period Beginn 01/01/01 Ending: 12/31/01 Page 6A

# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,844	\$ 2,844
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				1,158	1,158
20	V	6 Maintenance				9,122	9,122
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,700	1,700
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				25,207	25,207
30	V	18 Directors Fees				3,947	3,947
31	V	19 Professional Services				9,679	9,679
32	V	20 Fees, Subscription, Promotion				3,721	3,721
33	V	21 Clerical & General Office Expenses				136,870	136,870
34	V	22 Employee Benefits & Payroll Taxes				19,428	19,428
35	V	23 Inservice Training & Education				746	746
36	V	24 Travel and Seminar				5,299	5,299
37	V	25 Other Admin, Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,398	1,398
39	Total		\$			\$ 221,119	\$ * 221,119

Sum\_6A

2844

1158

9122

1700

25207

3947

9679

3721

136870

19428

746

5299

1398

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number HERITAGE MANOR-DWIGHT # 0037853 Report Period Beginn 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V 27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V 30	Depreciation				6,131	6,131
17	V 31	Amortization of Pre-Op & Org				0	
18	V 32	Interest				(79)	(79)
19	V 33	Real Estate Taxes				0	
20	V 34	Rent-Facility & Grounds				6,535	6,535
21	V 35	Rent-Equipment & Vehicles				13,648	13,648
22	V 36	Other				0	
23	V 38	Medically Nec Transportation				0	
24	V 39	Ancillary Service Centers				0	
25	V 40	Barber and Beauty Shops				0	
26	V 41	Coffee and Gift Shops				0	
27	V 42	Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 26,235	\$ * 26,235

Sum\_6B

6131

-79

6535

13648

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT # 0037853 Report Period Beginnin 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Adjustment for Related Organization	\$ 188,209	Heritage Enterprises, Inc.		\$	\$ (188,209)
16	V						
17	V	10a Adjustment for Related Organization	198,204	Green Tree Pharmacy	100.00%	300,164	101,960
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 386,413			\$ 300,164	\$ * (86,249)

Sum\_6C

-188209

101960

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6D

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6E

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.



SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6F

Facility Name & ID Number HERITAGE MANOR-DWIGHT # 0037853 Report Period Beginn 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6F

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6G

Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginn 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6G

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6H

Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginn 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ *	

Sum\_6H

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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STATE OF ILLINOIS

Page 6I

Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginn 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6I

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853Report Period Beginning: 01/01/01Ending: 12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	25.98%	28,552	10	0.20	Directors Fees	\$ 1,200	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	28,552	10	0.20	Directors Fees	1,201	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	20.00%	28,552	10	0.20	Directors Fees	1,201	line 18, col 7	3
	Joe Warner	President	Management	2.50%	10,197			Directors Fees	429	line 18, col 7	
4	Bill Froelich	Chairman of Board	Management	25.98%	98,495	10	0.20	Salary	4,143	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	96,894	10	0.20	Salary	4,077	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	20.00%	81,867	10	0.20	Salary	3,445	line 17, col 7	6
7	Joe Warner	President	Management	2.50%	110,233	48	0.95	Salary	4,638	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.80%	59,996	50	1.00	Salary	2,524	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.31%	50,403	50	1.00	Salary	2,121	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.26%	48,786	50	1.00	Salary	2,053	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.17%	33,519	40	1.00	Salary	1,410	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.21%	31,906	50	1.00	Salary	1,343	line 17, col 7	12
13								TOTAL	\$ 29,785		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME  
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)  
PORTS.

Facility Name & ID Number **HERITAGE MANOR-DWIGHT**# **0037853** Report Period Beginning: **01/01/01**Ending: **12/31/01**

## VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Heritage EnterprisesStreet Address 115 W. JeffersonCity / State / Zip Code Bloomington, ILPhone Number ( )Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,328	23	\$ 71,961	\$ 71,961	92	\$ 2,844	1
2	2	Food Purchase	BEDS	2,328	23	0	0	92	0	2
3	3	Housekeeping	BEDS	2,328	23	0	0	92	0	3
4	4	Laundry	BEDS	2,328	23	0	0	92	0	4
5	5	Heat & Other Utilities	BEDS	2,328	23	29,301	0	92	1,158	5
6	6	Maintenance	BEDS	2,328	23	230,824	54,124	92	9,122	6
7	7	Other	BEDS	2,328	23	0	0	92	0	7
8	9	Medical Director	BEDS	2,328	23	0	0	92	0	8
9	10	Nursing & Medical Records	BEDS	2,328	23	0	0	92	0	9
10	11	Activities	BEDS	2,328	23	0	0	92	0	10
11	12	Social Service	BEDS	2,328	23	0	0	92	0	11
12	13	Nurse Aide Training	BEDS	2,328	23	43,025	0	92	1,700	12
13	14	Program Transportation	BEDS	2,328	23	0	0	92	0	13
14	15	Other	BEDS	2,328	23	0	0	92	0	14
15	17	Administrative	BEDS	2,328	23	637,854	637,854	92	25,207	15
16	18	Directors Fees	BEDS	2,328	23	99,885	0	92	3,947	16
17	19	Professional Services	BEDS	2,328	23	244,928	0	92	9,679	17
18	20	Fees, Subscription, Promotion	BEDS	2,328	23	94,145	0	92	3,721	18
19	21	Clerical & General Office Exp	BEDS	2,328	23	3,463,403	3,114,857	92	136,870	19
20	22	Employee Benefits & Payroll	BEDS	2,328	23	491,614	0	92	19,428	20
21	23	Inservice Training & Education	BEDS	2,328	23	18,866	0	92	746	21
22	24	Travel and Seminar	BEDS	2,328	23	134,093	0	92	5,299	22
23	25	Other Admin. Staff Transport	BEDS	2,328	23	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,328	23	35,366	0	92	1,398	24
25	TOTALS					\$ 5,595,265	\$ 3,878,796		\$ 221,119	25

Print Preview

Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853 Report Period Beginning: 01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	\$ 0	\$ 0	92	\$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	92	6,131	2
3	31	Amortization of Pre-Op & Or	BEDS	2,328	23	0	0	92	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	92	(79)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	92	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	92	6,535	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	92	13,648	7
8	36	Other	BEDS	2,328	23	0	0	92	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	92	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	92	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	92	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	92	0	12
13	42	Other	BEDS	2,328	23	0	0	92	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 663,885	\$		\$ 26,235	25



Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853 Report Period Beginning: 01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853 Report Period Beginning: 01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853 Report Period Beginning: 01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853 Report Period Beginning: 01/01/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Dwight Continental Manor		XX	Mortgage	\$5,208.00	03/01/93	\$ 500,000	\$ 15,625	03/01/02	0.0825	\$ 28,058	1	
2											0	2	
3			XX	Interest Income							(79)	3	
4												4	
5												5	
	Working Capital												
6												6	
7											0	7	
8												8	
9	TOTAL Facility Related				\$5,208.00		\$ 500,000	\$ 15,625			\$ 27,979	9	
	B. Non-Facility Related*												
10	Interest Income										97	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 97	14	
15	TOTALS (line 9+line14)						\$ 500,000	\$ 15,625			\$ 27,882	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **HERITAGE MANOR-DWIGHT**# **0037853**

Report Period Beginning:

**01/01/01**

Ending:

**12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.	\$	<b>35,989</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>35,676</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(313)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>37,461</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>37,148</b>	<b>7</b>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996		<b>8</b>
	1997		<b>9</b>
	1998		<b>10</b>
	1999		<b>11</b>
	2000		<b>12</b>
<b>FOR OFF USE ONLY</b>			
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2000 \$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATIC \$	<b>16</b>

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

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**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

To Print this page only

**Hold down  
Control Key and hit r**

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME HERITAGE MANOR-DWIGHT COUNTY LIVINGSTON

FACILITY IDPH LICENSE NUMB0037853

CONTACT PERSON REGARDING THIS REPCRAIG L. ATER

TELEPHONE ( 309 )823-7135 FAX # (      )

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>050504483002</u>	<u>HERITAGE MANOR-DWIGI</u>	\$ <u>899</u>	\$ <u>899</u>
2. <u>050504483011</u>	<u>HERITAGE MANOR-DWIGI</u>	\$ <u>612</u>	\$ <u>612</u>
3. <u>050504483001</u>		\$ <u>34,166</u>	\$ <u>34,166</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>35,677</u></u>	\$ <u><u>35,677</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		1989	\$ 0	1
2	Nursing Home				2
3	TOTALS			\$	3

Print Preview



Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning: 01/01/01 Ending: 12/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92				\$ 0	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	1992 Improvements				8,456						9
10	1993 Improvements				586,243						10
11	1994 Improvements				12,874						11
12	1995 Improvements				496						12
13	Water Heater			1996	7,350						13
14	Interior Rehab (see attached)			1997	118,804						14
15	Garbage Disposal			1997	983						15
16											16
17	Parking Lot			1998	2,717						17
18	Interior Rehab			1998	17,242						18
19											19
20	Alarm Repair/Replacement			1999	1,120						20
21	Air Conditioning Unit			1999	2,461						21
22	Shower Room Repair			1999	6,345						22
23											23
24	Fire Dampers			2000	1,290						24
25	Boiler			2000	1,540						25
26											26
27	Water Heater			2001	7,200						27
28	Window Replacements			2001	4,437						28
29	Flooring -- Kitchen			2001	604						29
30	Code Alert System			2001	933						30
31	Motor Reolacement--A/C			2001	1,398						31
32											32
33											33
34	C/O Allocation							6,131	6,131		34
35	Book Depreciation					78,838		78,838		616,601	35
36					782,493						36

\* Total beds on this schedule must agree with page 2.

See page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B  
0 Page 12C  
0 Page 12D  
0 Page 12E  
0 Page 12F  
0 Page 12G  
0 Page 12H  
0 Page 12I

Facility Name &amp; ID Numbe HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning:

01/01/01 Ending: 12/31/01

**XI. OWNERSHIP COSTS (continued)**
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 0	\$ 78,838		\$ 84,969	\$ 6,131	\$ 616,601	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name &amp; ID Numbe HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning:

01/01/01 Ending: 12/31/01

**XI. OWNERSHIP COSTS (continued)**
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 616,601	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 616,601	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 616,601	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 616,601	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Numbe HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning:

01/01/01 Ending: 12/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 616,601	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 616,601	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down  
Control Key and hit t

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 616,601	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 616,601	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down  
Control Key and hit w

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 616,601	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 616,601	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.





Facility Name & ID Number **HERITAGE MANOR-DWIGHT**# **0037853**Report Period Beginning: **01/01/01** Ending: **12/31/01****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 275,194	\$ 34,881	\$ 34,881	\$		\$ 197,445	71
72	Current Year Purchases	29,909						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 305,103	\$ 34,881	\$ 34,881	\$		\$ 197,445	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,087,596	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 113,719	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,850	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,131	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 814,046	85

\*\*

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

[Print Preview](#)

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		92	03/06/92	\$ 131,876			3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 131,876			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☒ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipm: \$ 15,708 Description: Copier, Cell Phone and Central Office Allocation

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 03/06/92

Ending 03/01/02

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_

13. /2002 \$ \_\_\_\_\_

14. /2003 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-DWIGHT

#

0037853Report Period Beginning: 01/01/01 Ending: 12/31/01**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)****A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES  
DURING THIS REPORT  
PERIOD?☐ YES☐ NOIf "yes", please complete the remainder  
of this schedule. If "no", provide an  
explanation as to why this training was  
not necessary.2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE \_\_\_\_\_

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE \_\_\_\_\_

**B. EXPENSES****ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		50		50
3	Classroom Wages (a)		0		
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 50	\$	\$ 50
10	SUM OF line 9, col. 1 and 2 (e)	\$ 50			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**In the box below record the amount of income your  
facility received training aides from other facilities\$ **D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-DWIGHT# 0037853

Report Period Beginning:

01/01/01

Ending:

12/31/01

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1	2	3	4	5	6	7	8	
		Schedule V	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units	Total Cost	
		Line & Column Reference	Units of Service	Cost	Units	Cost	(Actual or Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 37,605			\$ 37,605	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			9,288			9,288	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			62,984	0		62,984	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				300,164		300,164	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				4,585			4,585	13
14	TOTAL			\$		\$ 114,462	\$ 300,164		\$ 414,626	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -13456  
st adj 5172  
Ot adj -4507

drugs 101960

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number HERITAGE MANOR-DWIGHT

# 0037853

Report Period Beginning: 01/01/01

Ending:

12/31/01

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 11,264	\$	1
2	Cash-Patient Deposits	7,542		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	332,255		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,117		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	166,945		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 546,123	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	0		13
14	Buildings, at Historical Cost	782,494		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	305,103		16
17	Accumulated Depreciation (book methods)	(814,046)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	0		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 273,551	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 819,674	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 56,011	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,542		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,596		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,103		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,461		32
33	Accrued Interest Payable	106		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36		0		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 220,819	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	15,625		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 15,625	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 236,444	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 583,230	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 819,674	\$	48

\*(See instructions.)

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**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>514,450</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>audit Adjustment</b>	<b>0</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>514,450</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>68,780</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>68,780</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>583,230</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

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